

**Consent to Release/Obtain Information**

I, \_\_\_\_\_, Date of Birth, \_\_\_\_\_, authorize the release of my protected health information (PHI) as indicated below between the YWCA of Fort Dodge and:

Name of Individual(s) or Treating Provider: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Yes  No Substance Use Disorder/ Mental Health Records

I understand that my health record contains information relating to treatment of substance use.

I authorize the Following PHI to be Released from my health record:

To be released by YWCA: (Check Yes or No)			To be released to YWCA: (Check Yes or No)		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Presence in Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Assessment/Evaluation/ASAM Results
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Participation in Treatment/Group	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Participation in Treatment
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Assessment/Evaluation/ASAM Results	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Progress Notes/Summary
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Progress Notes/Summary	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alcohol and other Drug use history
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alcohol and other drug use history	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Discharge Summary/Information
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug/Alcohol screening results	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug/Alcohol screening results
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychological Evaluation/Notes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medical History/Information
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Discharge summary/ Information	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychological Evaluation/Notes
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Critical Incident Report	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Critical Incident Report
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other (Specify): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other (Specify): _____

Purpose of the Disclosure (Select all that Apply):

Insurance  Legal  Personal  Coordination of Treatment Services  
 Other (Specify) : \_\_\_\_\_

By signing this consent form, I understand that:

- I have the right to receive a copy of this consent form.
- My records are protected under the Federal Regulations Governing Confidentiality of Substance Use Disorder Patient Records Act, 42 CFR Part 2 and HIPAA 45 C.F.R. Part 160 & 164
- 42 CFR Part 2 prohibits unauthorized disclosure of these records.
- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and in any event, this consent expires Automatically 12 months after signature Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date